MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Payers

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, and/or 2017 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the templates, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

Pre-Filed Testimony Questions

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.
   (1) UniCare is concerned that rising drug prices will thwart the Commonwealth's ability to meet the revised benchmark. In particular, the rising cost of specialty drugs is a key concern along with the increased pricing strategies for drugs that have already been available on the market for some time. Additionally, UniCare remains concerned about the impact on the market due to the introduction of very highly priced new drugs.
   (2) UniCare is also concerned about the market trends associated with not only the consolidation of providers but also the shift of services from community based facilities to academic medical centers.

b) What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?
   (i) UniCare believes there are a number of policy measures that could be enacted at the federal level that would address the pricing dynamics within the drug industry. In particular, pharmaceutical manufacturers often engage in anticompetitive and other tactics that increase costs in ways that are gaming the system and should be stopped by the federal government. We are supportive of action in the following areas: **REMS reform:** We applaud the Food and Drug Administration's (FDA's) recent efforts to reform the Risk Evaluation and Mitigation Strategies (REMS) system to stop efforts from manufacturers to block generics from the market by limiting a generic manufacturer's ability to obtain a branded sample; **Pay-for-delay:** We believe that greater action and transparency is needed when a manufacturer is using financial incentives to induce a generic manufacturer to not produce a drug (i.e. pay-for-delay). We encourage the Federal Trade Commission (FTC) to continue monitoring these arrangements, pursue litigation and file *amicus* briefs when necessary, and advise Congress on a legislative solution prohibiting such agreements; and, **"Evergreening" and "Product hopping:"** Actions should be taken to discourage these two manufacturer tactics that mitigate the market impact of generics by creating new products that are similar to old products.

   (ii) UniCare along with many academic researchers believes that the consolidation of healthcare providers and hospitals has a direct impact on pricing within a given market. For example, the Robert Wood Johnson Foundation has published research that suggests prices for hospital services can increase 40% or more when merging hospitals are closely located. We believe this continuing national trend

requires additional attention from the Federal Trade Commission (FTC). We believe that robust review and action by the FTC on hospital merger applications would have the most impact. The FTC should pay significant attention to hospital mergers and acquisitions to evaluate the impacts that provider consolidation will have on healthcare prices and seek to block those that are anti-competitive.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.
   (1) Continuing movement of alternative approaches to provider payment including gain sharing arrangements with large entities, value-based payments with mid-sized practices and bundled arrangements for targeted surgical procedures.
   (2) Deployment of member-centric customer service and medical management concierge-type models to effectuate improvement in health care management, enhanced quality of care and use of appropriate levels of care.
   (3) Introduction of pilot programs with innovative practices offering different approaches to patient management with extensive use of ancillary staff and electronic access for the members.

2. INFORMATION ON PHARMACY BENEFIT MANAGERS

The HPC, other state agencies, payers, providers, and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. Pharmacy benefit managers (PBMs) play a major role in the market, significantly impacting drug pricing and access. Furthermore, PBM policies that restrict the ability of pharmacies and pharmacists to share certain information with patients have been an increasing area of focus.

a) Please identify the name of your organization's contracted PBM(s), as applicable.
UniCare does not offer a PBM in Massachusetts and thus has not answered the questions below.

b) Please indicate the PBM's primary responsibilities below [check all that apply]
   ☐ Negotiating prices and discounts with drug manufacturers
   ☐ Negotiating rebates with drug manufacturers
   ☐ Developing and maintaining the drug formulary
   ☐ Pharmacy contracting
   ☐ Pharmacy claims processing
   ☐ Providing clinical/care management programs to members
   ☐Other: Click here to enter text.

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.).
Required Answer: Click here to enter text.

d) Does your organization or any PBM with which you contract have policies that restrict the information a pharmacy or pharmacist can share with a covered person on the amount of the covered person's cost share for the prescription drug compared to self-pay (so-called "gag clause")? If yes, briefly describe this policy.
Required Answer: Click here to enter text.

e) Does your organization or any PBM with which you contract have policies requiring a pharmacy to charge or collect a copayment from a covered person even if that amount exceeds the total charges submitted by the network pharmacy? If yes, briefly describe this policy.
Required Answer: Click here to enter text.

f) Does your organization or any PBM with which you contract have policies requiring a pharmacy to proactively disclose to a covered person if the total charges submitted by the network pharmacy are less than the required copayment? If yes, briefly describe this policy.
Required Answer: Click here to enter text.

3) STRATEGIES TO PROMOTE INNOVATIVE CARE DELIVERY THAT INTEGRATES BEHAVIORAL, SOCIAL, AND MEDICAL CARE

Public and private payers alike are implementing new policies to support the development and scaling of innovative, high-quality, and efficient care delivery, such as, for example, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, reimbursement for services rendered by peers and community health workers, and incentives for patients and providers to engage in evidence-based treatment for substance use disorder.

Has your organization adopted policies related to any the following areas of care delivery improvement and innovation? [check all that apply, and describe your primary incentive related to the care delivery innovation in the fields below]

☒Readmissions Other (please describe in a text box)
☒Avoidable emergency department (ED) visits Co-Payment Reduction or Elimination
☐Behavioral health integration into primary care (e.g., collaborative care model)
Required Answer: Click Here
☒Pharmacologic or other evidence-base therapies for substance use disorder
Co-Payment Reduction or Elimination
☐Peers and/or community health workers Required Answer: Click Here
☒Telehealth/telemedicine Co-Payment Reduction or Elimination
☐Non-medical transportation Required Answer: Click Here
☐Supportive temporary or permanent housing Required Answer: Click Here
☒Other: Click here to enter text. Required Answer: Click Here

Appendix: Question 3 Strategies: Explanations

Readmissions: Other – UniCare will be adopting a claims payment policy to forego any additional payment to a hospital in Massachusetts when the member is readmitted within 30 days to the same facility for the same DRG. All acute care admissions to hospitals in Massachusetts are paid by DRGS for inpatient care.

Avoidable emergency room (ED) visits: Copayment Reduction and Elimination. UniCare, working in partnership with the Group Insurance Commission, has aligned member financial incentives in order to reduce inappropriate emergency room use. Members have a significantly reduced copayment for the use of urgent care centers as compared to the Emergency Department copayment. UniCare has and is continuing a comprehensive member education campaign to increase the use of urgent care centers as an alternative to inappropriate Emergency Room utilization.

Pharmacologic or other evidence-based therapies for Substance Use Disorder: Copayment Reduction and Elimination. Members have no member cost-share for physician visits for pharmacologic treatment of Substance Use Disorders (SUD) and no member cost-share for office visits for assessment and referral for Substance Use Disorder.

Telehealth/telemedicine: Copayment Reduction and Elimination. UniCare offers telehealth visits for both medical and behavioral health concerns with copayments that are less than the usual office visit.

4) STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available "price transparency tool."

a) In the table below, please provide available data regarding the number of individuals that sought this information:

Health Care Service Price Inquiries CY2017-2018			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**	2250	690
	Q2	1894	898
	Q3	1956	700
	Q4	2411	957
CY2018	**Q1**	2226	763
	Q2	1623	680
	TOTAL:	12,360	4,688

b) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?
UniCare provides timely responses to consumers regarding price information for admissions as well as certain procedures and services through its transparency website application and through its customer support units. Quotes about pricing are generally estimates and therefore inherently subject to inaccuracy. Two driving factors for the use of estimates are: 1) the ability of the consumer to definitively identify the services expected to take place; 2) the use of aggregated claims data to develop "average" values for the services, thus not precisely accurate for any given case.

c) What barriers do you encounter in accurately/timely responding to provider inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?
UniCare has not received inquiries from providers on price information to any extent measurable.

5) INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2015 to CY2017 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2015 to 2017, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.
Required Answer: Click here to enter text.

6) INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND AND ALIGN APMS

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2017 Cost Trends Report, the HPC recommended the Commonwealth continue to promote the increased adoption of alternative payment methodologies (APMs) from present levels of 59% of HMO patients and 15% of PPO patients in 2016. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a) Please answer the following questions related to risk contract spending for the 2017 calendar year, or, if not available for 2017, for the most recently available calendar year, specifying which year is being reported. (Hereafter, a "risk contract" shall mean a contract that incorporates a budget against which claims costs are settled for purposes of determining the surplus paid or deficit charged to a provider organization.)
   i) What percentage of your organization's covered lives, determined as a percentage of total member months, is HMO/POS business? What percentage of your covered lives is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)
      1. HMO/POS 0%
      2. PPO/Indemnity Business 100%

ii) What percentage of your HMO/POS lives is covered under a risk contract? What percentage of your organization's PPO/indemnity lives is under a risk contract?

1. HMO/POS Not applicable
2. PPO/Indemnity Business 52.4%

iii) What percentage of your organization's HMO/POS lives is covered under a risk contract with downside risk? What percentage of your PPO/indemnity lives is under a risk contract with downside risk?

1. HMO/POS Not applicable
2. PPO/Indemnity Business 7.6%

b) Please answer the following questions regarding quality measurement in APMs.

i) Does your organization plan to implement the core and menu quality measure set in all of your future global-budget based APM contracts, as applicable, with Accountable Care Organizations (ACOs) as defined by the Executive Office of Health and Human Services' Quality Alignment Taskforce (see Appendix A)?

(a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?

(b) In Massachusetts, UniCare has a singular focus on public employees/retirees and is contracted with the Group Insurance Commission (GIC) to serve its members through administration of the UniCare State Indemnity Plan. As an indemnity plan, UniCare operates differently than other managed care plans and accordingly has not participated in either HEDIS reporting or MHQP reporting. Under the UniCare State Indemnity Plan, members are not required to choose Primary Care Physicians and have full freedom of choice in their selection of providers. While we encourage network participation, providers do not have to be contracted in order to be reimbursed by UniCare. This freedom is one of the attractive features of an indemnity plan and as such network arrangements are different than other managed care plans. UniCare has deployed several APM arrangements with providers and has used some of the Menu and Monitoring Measures in these arrangements as determinants of quality performance.

ii) What are your organization's priority areas, if any, for new quality measures for ACOs?

(a) UniCare is working with its large participating providers to implement APM arrangements that include targeted financial outcomes and gain sharing to introduce outcome-based quality measures. These measures are also aligned to the Core Measures list.

HPC Payer Exhibit 1

UniCare Life & Health Ins. Co.

All cells shaded in BLUE should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2015	3.5%	-1.5%	-1.9%	2.1%	2.1%
CY 2016	1.9%	1.8%	1.9%	-3.2%	2.4%
CY 2017	2.3%	-4.5%	0.2%	1.1%	-1.0%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.